JANUARY 1954

Mental Hospitals

Volume 5 Number 1

in this issue:

Published by
AMERICAN PSYCHIATRIC ASSOCIATION

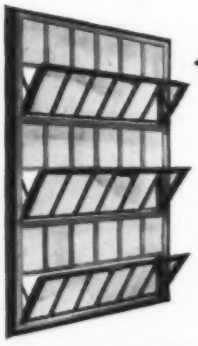
Special Building for "Avocational Therapy" at Silver Hill Foundation, New Canaan, Conn.

WHICH OF THESE

TRUSCON STEEL WINDOWS

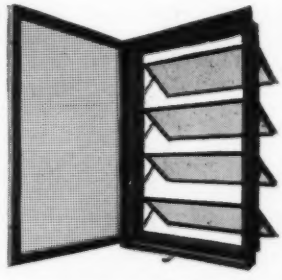
fit your detention needs?

All are detention-proved and safe. All are carefully engineered to protect mental patients against self-injury, and to conceal or minimize every indication of enforced restraint. All have extra margins of safety, allowing the use of large total glass and ventilating areas for abundant healing sunlight and fresh air. Truscon Steel Detention Windows are custom-built to meet your specific needs. Competent technical assistance is always available to help solve your particular window problem. Shown below are only three of the many Truscon detention window designs currently available. Write for your personal copy of the complete Truscon Window Catalog.



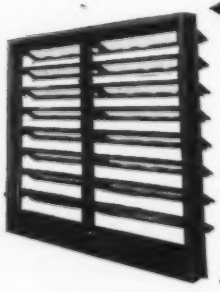
PSYCHIATRIC WINDOW

Suitable for detention of patients who are not inclined toward self-injury. Full 100% ventilation where desired. For example, window shown offers 50% ventilation. Degree of ventilator swing is controlled by limit stops. Furnished with bronze cam-acting locking handle, or concealed cam latch with removable key. Screens available for installation on the exterior side.



INTERMEDIATE LOUVER WINDOW

Particularly applicable to the needs of mental hospitals. Awning type design with 100% ventilation. Degree of opening of simultaneously operated vents is controlled with small removable crank, permitting operation by authorized attendant only. Principal restriction against injury or escape of patient is provided by detention screen opened only by removable key, also carried by attendant.



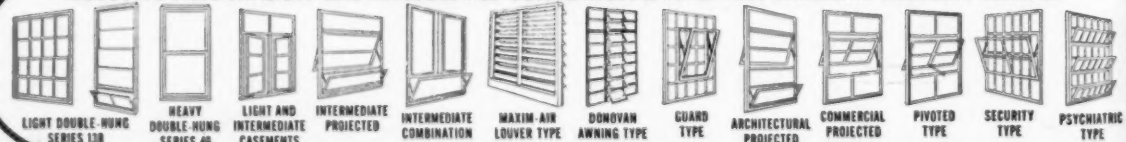
MAXIM-AIR® WINDOW

Suitable for use in mental institutions where moderate restraint will suffice. Awning type, with 100% ventilation as standard. Available in single, double or triple designs, built integral and controlled with a single operating handle. Size of vents and degree of opening may be designed to meet any requirement. For rooms housing violent patients, restraint and protection from injury may be further provided by detention screens.

TRUSCON® STEEL DIVISION REPUBLIC STEEL CORPORATION

1112 ALBERT STREET • YOUNGSTOWN 1, OHIO

TRUSCON'S STEEL WINDOW LINE INCLUDES ALL CONVENTIONAL TYPES PLUS EXCLUSIVE TRUSCON DESIGNS



THIS MONTH'S COVER

"Since all interpersonal relationships are somewhat unsatisfying, only purposive occupation can give direction and significance, a relative sense of fulfillment, to an individual's life," writes Dr. William B. Terhune, Medical Director of The Silver Hill Foundation, New Canaan, Conn. The building on this month's cover represents the application of this philosophy to the rehabilitation of psychoneurotic patients.

Occupational therapy is an old idea, but at Silver Hill the philosophy has been broadened, not only to restore the patient to usefulness, but to enrich his life when he leaves the hospital. The foundation believes that the pursuit of a hobby acquired during hospital life may help to prevent recurrence of the emotional disturbance.

Before starting the new building, the Board of Managers of Silver Hill conducted a national survey of existing facilities. The combined talents of architects and advanced therapists resulted in the new "salutarium."

"Avocational Therapy" is a required part of the treatment program, and the therapists take an active part in medical conferences to integrate into the clinical program the realistic progress of each patient as shown by his work and behavior while under their guidance. Doctors visit the shops regularly; they do not consider their patient's activities as "busy work" merely to occupy spare time.

Since the activities are designed to give productive pleasure to the patients both now and in the future, each one can develop the hobby of his choice. In the art studio anyone can paint a picture; in the carpentry shop a boat was built—"only a little smaller than the Queen Mary!" A woman patient bragged "I've made my summer wardrobe almost entirely, and I've never sewn a stitch before."

"To be helpful or medically effective occupational therapy must be purposive, constructive, skillful or preferably artistic," says Dr. Terhune. "It then provides self-expression through intelligent emotional discipline. . . . It counteracts absorption in suffering . . . indicates the need for relaxed effort, and encourages the acceptance of frustration with a minimum of personality disturbance. . . . By restoring confidence it strengthens the sick ego and it is particularly useful as an adjunct to psychotherapy, physiological treatment and environmental manipulation."

Mental Hospitals

January, 1954
Volume 5 Number 1

CONTENTS:

Published monthly, 10 times a year, September through June, for staff members of mental hospitals, schools and related institutions which subscribe to the American Psychiatric Association Mental Hospital Service. Institutional subscription rate $2.50 a year. Individual subscription rate for staff members of subscribing institutions, $2.50 a year. Published by the American Psychiatric Association Mental Hospital Service, 1785 Massachusetts Avenue, N. W., Washington, D. C. Entered as Second Class mail matter, August 1st, 1952, at the Post Office, Washington, D. C., under act of March 3, 1879.

PLANNING FOR RESEARCH IN MENTAL HOSPITALS

By PAUL E. HUSTON, M.D., Ph.D.

Department of Psychiatry, College of Medicine, Iowa City, Iowa

The mounting number of psychiatric patients in our hospitals, the long chronicity of schizophrenia and the increasing importance of geriatric psychiatry all emphasize the need for research, declared my former colleague, Dr. J. S. Gottlieb, when he spoke at the Fourth Mental Hospital Institute in Columbus in 1952.

Psychiatrists have long recognized this need, but with the overwhelming needs of patient care, research has been postponed. More patients, needing more buildings and more staff, both in chronically short supply, have led to neglect of the only means whereby the burden can ultimately be relieved.

To break away from this treadmill, it would seem that the public mental hospitals will have to develop, *on their own*, better treatment techniques for such illnesses as schizophrenia and psychoses associated with aging. Research must receive a much more prominent role in every mental institution, even under present difficulties.

What are the requirements for research? Research requires ideas, trained personnel, clinical material, money, space, free time, and organization.

In the succeeding paragraphs I wish to comment briefly on these requirements. I shall not elaborate on the need for clinical material since most hospitals contain an ample supply. Concerning money, we note only that a stable program requires that the research budget be a continuing yearly item. While space for research depends on the nature of the project, research assigned to a linen closet or a basement room will not have proper status.

Sometimes we hear the pessimistic view that significant research awaits the emergence of a brilliant idea. A grain of truth exists in this view. For example, nearly every organ system, heredity, past experience, and the culture have been implicated as the major cause of schizophrenia, but none has been proven. Again nearly every imaginable treatment—brain operations, shock, various drugs, group and individual psychotherapy, etc., has been tried with results not much different from a "spontaneous" remission rate. One may argue, then, that nothing really important will appear without a brand new conception. Yet a new concept cannot emerge until the groundwork for it has been laid. A survey of the current scene regarding schizophrenia suggests that we really suffer from a plethora of ideas, mainly in the form of speculations. Many of these need to be put to scientific test. It is futile and defeatist to delay research until some genius has announced another approach.

The dearth of research personnel is a serious bottleneck. Few psychiatrists plan a career in research. To break this bottleneck, research needs a high priority in each hospital with the research jobs paying as well as other jobs and with the same degree of tenure. A research orientation given to the residence training program of the hospital, with emphasis on scientific methodology, may help encourage new personnel. Residents should have an opportunity for practical research experience. Each hospital, out of its budget, might provide one or more research fellowships to enable promising young psychiatrists to continue research after the residency. Serious consideration should also be given to the Markle* type of fellowship, which guarantees financial support to an investigator over a period of years. This permits him to plan and carry out projects on a long-term basis.

The clinician who participates in research needs free time. Unless he has this, the inevitable encroachments of emergency situations on the ward, telephone calls, visiting relatives, etc., press in upon the research time, which eventually becomes a luxury and disappears. Research requires periods of uninterrupted critical reflection. It cannot be stimulated or regulated by hours on duty. The hospital superintendent should not be upset if some of his research-minded colleagues disappear from the hospital occasionally when they are supposed to be doing research. At Worcester in the 1930's when I was associated with the research department we used to refer humorously to these periods of reflection as "umbiloscopy." We were expected to retire into ourselves to think about the significance of our work. Doctor R. G. Hoskins, the director of research, encouraged this and often cited the example of Professor Walter Cannon, the Harvard physiologist, who had the habit of spending his summers in a cabin in Vermont. To the superficial observer he was unoccupied; actually he was planning the experiments which he conducted in Boston the following winter.

Need for Organization?

One of the first questions which occurs to an administrator who wishes to start research is that of organization. A prior question is whether the research needs to be organized at all. As in most other questions involving research, the answer comes back to the nature of the problem under study. Much research needs little or no formal organization. Three staff members, for example, might study three different problems, the only points of crossing being the common use of certain laboratory facilities and patients. Here a time and work schedule coordinated with the laboratory and ward would suffice.

But where a project involves several investigators, some type of organization becomes necessary. If the project remains within one of the fairly well-defined scientific disciplines and involves only a few persons, a simple organization is sufficient. Thus

---

**The John & Mary R. Markle Foundation, 14 Wall St., N. Y. 5, in cooperation with accredited medical schools in the U.S. and Canada has a fellowship program to aid young scholars in medical science. The purpose is to provide opportunity for promising scientists to develop as teachers and investigators who can make important contributions to medical science.*

in studying steroid metabolism of schizophrenia, the organization might include a psychiatrist as the leader, plus a biochemist and laboratory technicians.

The Research Team

Today, however, we emphasize the multi-discipline approach to psychiatric problems. The complexity of the field of mental disorder and the theory of multiple causation have gradually increased the number of interested professions and so a team concept of research organization has emerged. It is scarcely possible to consider some research problems without including the sociologic, anthropologic, psychologic, biochemic, and pathologic aspects. Thus, a group of individuals of differing backgrounds is formed to work on a central project. This team may start off with enthusiasm and smooth coordination, but there are forces which cause its members to drift apart. Aside from personal frictions, there are many reasons for this. Different professional groups, with their own special terminologies, have trouble in communication. Also, in inter-disciplinary projects there tends to develop a status problem; the members of one discipline come to feel that their approach to the project is the most pertinent. First this appears as an ideologic discussion, then it becomes more personal by attempts to increase the number of members of a certain discipline and to enlarge its laboratory space and its budget. Personal frictions become heightened and little cliques form. Again, with the passage of time, side projects appear. These involve new methods or the preliminary exploration of new ideas. Some member of the group proposes a project, very worthy by itself, but bearing only a remote relationship to the central project. He feels almost compelled to carry out this project for he may make a significant contribution and a name for himself.

How does one keep inter-disciplinary projects or projects involving large numbers of people oriented toward the main goal? Collaborative research begins with the recognition that the several persons engaged bring different skills and attitudes to the project in addition to their own differing personalities. (It is usually very difficult to incorporate the prima donna personality into a collaborative program.) In this collaboration a process of mutual education takes place, so that the attitudes of the several participants become understood and respected. Out of collaboration a more comprehensive view of the project emerges.

Usually the single most powerful force for integration in the project is the attitude of the director. He keeps the work moving toward the main goal. A research-oriented psychiatrist is usually the best person for this direction. The breadth of his training and his intimate knowledge of patients yields an ability to decide what is clinically relevant or irrelevant to the project. In addition, he can protect the therapeutic needs of patients used in research. He can assume legal responsibility for these patients and can more easily make arrangements with nurses and others for the management of patients than can non-medical personnel.

Regular Meetings Help

There are a number of devices which the director can use to hold a project together. One of these is a regular meeting of the members of the group to discuss the progress of the project and to clarify objectives and methods. This may be combined with a research seminar or a journal club in which material relevant to the research is presented. Of special value is a discussion of each phase of the project by the whole group before the actual work is undertaken. Here the different attitudes of the separate disciplines sharpen and clarify the project. Reports to the entire group on completion of each phase of the project also tap individual contributions through discussion, and enhance group spirit. A similar technique can be extended to papers being prepared for publication.

Doctor William Bryan, former Superintendent of the Worcester State Hospital, once said that the research unit was one of the most valuable parts of total hospital operation. It provided a stimulus and spirit to the hospital which completely altered and revitalized its characters. Because of it, psychiatrists and others were attracted to Worcester for training from all over the country. He believed that research would lighten the tremendous patient load of the hospitals. Before starting the research he formed a planning committee within the hospital. Since the committee was composed of persons who might be involved in research, they became enthusiastic and actively supported it. Bringing all the departments of the hospital into the program at the planning stage helps the research organization function smoothly.

"Activity Group Therapy"

Reviewed for MENTAL HOSPITALS by

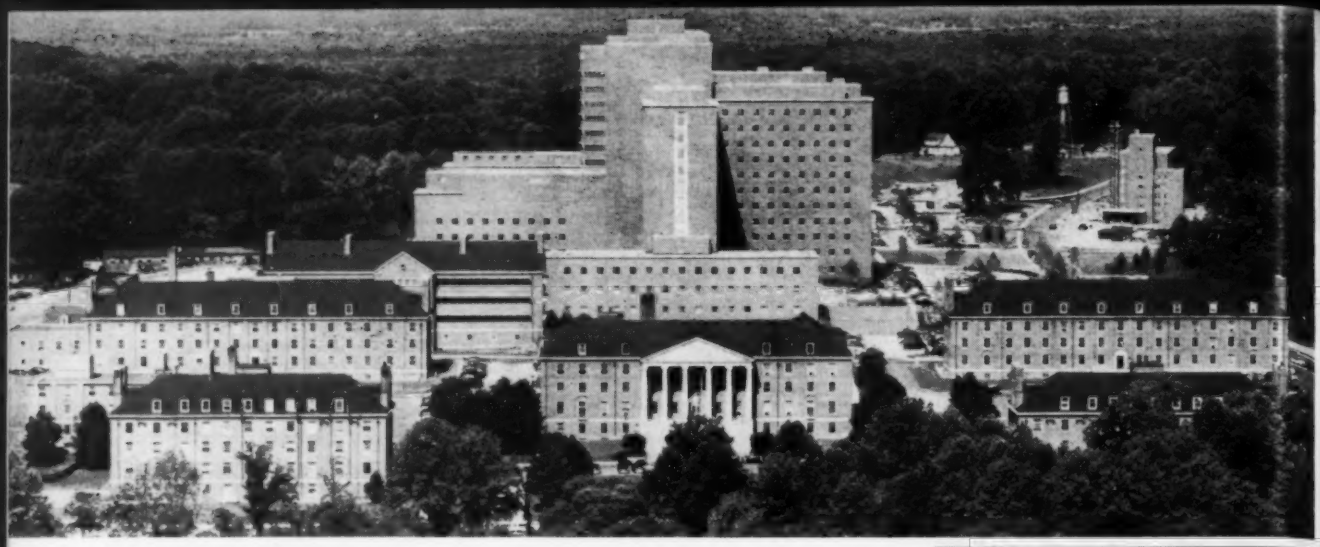
JOHN J. BLASKO, M.D.
Chief, Psychiatric Training,
VA Central Office

This black and white sound film, which runs 50 minutes, was produced by the Jewish Board of Guardians, and is now available on loan to M.H.S. members. Booking Request forms are enclosed.

The film was obtained by having concealed cameras and microphones in an activity room where a selected group of children from 9 to 11 met once a week for 65 sessions. Scenes of the various sessions are shown, with particular emphasis on a withdrawn child, a hyperactive boy and an effeminate boy.

It particularly emphasizes the neutral role of the therapist who acts as an observer and is tolerant and accepting of any type of behavior as long as there is no actual danger to life or limb. In the film, the boys express their aggression by breaking the locks of the cabinets, building a fire on the table and by competing with one another with saws, knives, etc. The marked changes in the boys constituting this group are pretty definitely indicated in the film.

The film has great value from the standpoint of observing group dynamics in action. The principles portrayed in this film are applicable to adult groups where the therapist is there as a friend for support and help, and not as a prohibiter or restrainer. It would be good for showing to any type of hospital personnel, especially nursing groups, special services, physical medicine rehabilitation personnel and others.



Clinical Center, National Institutes of Health, Bethesda, Md.

Mandate for Psychiatric Research

By ROBERT A. COHEN, M.D.

Director of Clinical Investigations
*National Institute of Mental Health**

Robert A. Cohen, M.D.

The psychiatric hospital administrator has always been faced with the problem of meshing the routine services of his hospital with whatever research he and his staff may be interested in. His main goal is to provide service to the sick and disabled of the community he serves. And since the needs for care of the mentally ill are so pressing, he must think twice before he decides to devote some of his time, attention, or budget to research operations. Although he knows that research will in the long run contribute mightily to the goal of his hospital, he must always weigh such long-term and seemingly nebulous advantages against the demands for immediate service. The result must necessarily be that immediate service comes first. At the worst then, he must forego research opportunities, and all too often, reearch, if possible at all, can only be done on what might be called a bootleg basis.

For the harassed would-be researcher—or the administrator who wants to facilitate the researches of others—the psychiatric section of the Public Health Service's Clinical Center may seem to be a dream come true. For here at the Clinical Center we have no service obligations and in fact have a mandate to devote our time and attention solely to answering those questions about mental illness which have always bothered us. All of us are faced, therefore, with a heavy responsibility to make this ideal situation in hospital organization successful.

Opportunities for Collaboration Carefully Provided

The Clinical Center at Bethesda, Maryland, was planned around the idea that if specialists in the major chronic diseases were permitted to do research within the confines of one well-equipped, well-staffed building, an opportunity would be provided for mutual stimulation and cross-disciplinary inquiry. Interdisciplinary work was not to be imposed by direction, but rather, conditions were set up to allow maximum opportunities for such interdisciplinary contact and work. Already this arrangement has borne fruit. I might cite some examples within my own staff.

One doctor is collaborating with members of the Institute of Arthritis and Metabolic Diseases on a study of emotional factors influencing the onset and course of arthritis. Another joint NIMH and NIAMD project is the study of the current treatment of a case of metabolic disturbance that had been accompanied by pathological weight increase. The emotional concomitants for the patient of the rapid reduction of weight while under treatment will be investigated and correlated with the change in the body image. Other studies are projected in collaboration with the Heart Institute

* *All pictures of "patients" were posed by NIH staff members and their children.*

and the Institute of Neurological Diseases and Blindness.

Within our own clinical investigations branch of NIMH, we have brought together representatives of various disciplines and of various backgrounds within one discipline. Pharmacologists, biochemists, and neurologists work together with psychoanalysts, psychologists, and sociologists in an effort which, we hope, will contribute to the formulations of the behavorial sciences. The immediate interests of the unit are in the development of a theory of personality based upon objectively verified data, without which rational preventive and therapeutic measures directed against the functional disorders are impossible. I also hope that we shall be able to make some contributions to communication theory.

Basic research, as distinguished from clinical research, continues under the direction of Dr. Seymour Kety, head of basic research laboratories both for mental health and neurological diseases and blindness. These units are concerned with studies on the cellular or organ level, with animal research, and with certain pharmacological studies and socio-environmental studies, some of which may be carried out in collaboration with the clinical investigations staff.

Clinical Work in Progress with Two Groups

At the present time we have patients on two wards. By talking about them we can give an idea of what actual clinical work is now going on. On the adult ward we are studying disturbed schizophrenics. With these patients we are working on some questions about the psychotherapy of psychotics, the effects of a specialized nursing staff organization, the dynamics of the ward social structure, and certain EEG and biochemical phenomena. The children's ward is primarily organized around the idea of determining the indications and contraindications of a group residential treatment setting for various kinds of acting-out disorders. This study is linked to an inquiry into the factors responsible for the internalization of conflicts. We plan to compare these factors in the adults and children and to study, therefore, the cultural influences of age status in the formation of different illness patterns.

Dr. Marian Kies, NIMH biochemist, in clinical investigation laboratory.

Dr. Donald A. Bloch, Chief, Children's Service, studies play therapy through a one-way screen. Each observation room looks into two therapy rooms.

I want to emphasize that our clinical investigation activities are organized so that each researcher is free to choose his own topic; there is no direction from above as to which subjects will be studied by any of the principal investigators.

Reasearch Consonant with Treatment

All of our patients must be referred to us from other hospitals, from clinics, and from private physicians. No patient is *entitled* to enter the hospital, and the selection of patients depends upon the particular research requirements that have been decided upon. Once the patient is admitted, all steps are taken to assure that research procedures used in his case are consonant with the best treatment we know. The patient will be treated in the hospital or, upon discharge, followed for out-patient care, so long as research purposes are thereby furthered. Our staff—especially the social service department—also works with the patient's family as well as with appropriate social agencies. The patient is assured, moreover, of follow-up or continued treatment through the referral source whenever his connection with the Clinical Center is severed.

Intensive Study of a Few—Cooperation for Larger Studies

When the peak in-patient population is reached some years from now there will be a maximum of 98 psychiatric patients. Each ward will accommodate from 10-15 patients. This small number of patients for the wide variety of studies that are proposed and now getting underway poses a specialized research situation. It is quite apparent that we cannot do research within the Clinical Center on any hypothesis, the testing of which requires a large number of subjects. It is not practical to constantly admit and transfer patients for such a study. On the other hand, the Center is particularly suited, in architecture and in staffing, to do multiple studies of the same patients, and to permit the very intensive study of small numbers of patients. We plan, also, to work out cooperative arrangements with nearby hospitals in order to use their greater patient population for larger-scale research operations. In this way we can make the rather intensive studies which require a 24-hour observation of a single patient or a small group, and can collaborate in the extensive investigations which may require only a few observations or a few testing procedures but with many hundreds of patients.

"Normal Patients" Help to Control Observations

One final remark may especially interest those whose work is to run hospitals and care for patients, doing research as a sideline. While it is true that the distortions of behavior which one sees in the mentally ill person provide one with the data on nature's own experiments, it is still true that in research we can sometimes be led astray by dealing exclusively with the exaggerated symptoms of sick behavior. At the Clinical Center, then, we hope to have—and already have had—some normal subject-persons hospitalized. Naturally, relatively normal, healthy persons as hospital patients pose somewhat different problems, but in this way we will be able to check on and control our own observations and conclusions and amplify the generality of our efforts towards the development of a basic science of human behavior.

Photographs and story prepared for MENTAL HOSPITALS at the National Institutes of Health, Public Health Service, Department of Health, Education and Welfare.

BELOW: As in all mental hospitals, occupational and recreational opportunities are furnished both to adult and child patients.

▼ *INSET: Making music on the autoharp is fun to the little girl, but Dr. Fritz Redl, Chief, Child Studies, hears more than the notes she strikes.*

ARCHITECTURAL SUPPLEMENT

Mental Hospitals

JANUARY, 1954

ARCHITECTURAL STUDY

A Progress Report and an Appeal

By JOHN L. SMALLDON, M.D.
Director, Architectural Study Project

Since the initiation, in mid-September, 1953, of the A.P.A. Architectural Study Project, financed under grants from the Rockefeller Foundation and the Division Fund, a definite program has been developed, and the collection of pertinent material started.

The Project's Consultants, listed below, have been conscientious in attendance at regular meetings and unstinting with their time, advice and assistance.

Slocum Kingsbury, A.I.A., Washington, D. C.
Moreland Griffith Smith, A.I.A., Montgomery, Ala.
Winfred Overholser, M.D., Washington, D. C.
Harvey J. Tompkins, M.D., Washington, D. C.
Addison M. Duval, M.D., Washington, D. C.
Ralph M. Chambers, M.D., Washington, D. C.
Riley H. Guthrie, M.D., Bethesda, Md.

The architect-consultants have been appointed by the American Institute of Architects which is cooperating actively with us, and which plans to add two additional consultants at an early date.

The staff to date includes Alston G. Guttersen, architect, whose article on mental hospital architecture based on function according to modern psychiatric concepts is being reprinted in MENTAL HOSPITALS at the present time. The remaining present staff member is Joseph Turgeon, Administrative Assistant. It will soon be necessary to obtain larger office quarters to accommodate the mechanical engineer, specifications man, draftsmen and stenographer whose help is now required.

It is apparent that the breadth of the program planned, covering receiving and intensive treatment, medical and surgical, geriatric, disturbed, tuberculosis and other types of public mental hospital buildings, as well as psychiatric institutes, children's mental hospitals, institutions for the mentally defective, private mental hospitals and community mental health facilities, makes it impossible for our limited staff, even when brought up to full strength, to do an adequate, detailed study in two years.

We are, therefore, inviting assistance on specific projects from mental hospital psychiatrists who are especially interested in and have had experience with these problems. It is hoped that the A.P.A. members approached will be willing to participate in this work so important to us all, and that others will volunteer their services. We are anxious to hear from you if you have interest in particular projects, or if you have developed treatment programs in your hospital of value for certain types of patients.

On acceptance of a project, the psychiatrist will be teamed with an architect located in his area, who will be named by our architect-consultants from a list of over forty architects who have to date volunteered their help, and from others. These psychiatrist-architect teams will be furnished by our staff with check lists to assist them in making surveys and in producing material suitable for comparative analysis in our office.

A survey of public mental hospitals has been made to learn of new construction since 1946 and of construction planned for the next five years. Return postcards have been received to date from 128 of the 194 hospitals to which cards were sent. These 128 reports came from 42 states and from Canada. This remarkable response indicates the great interest in mental hospital design, construction and equipment.

The following data illustrates the valuable information obtained from these card reports:

Complete Mental Hospitals	
Built since 1946	0
Under Construction	6
Planned in next 5 years	2
Receiving and Intensive Treatment Buildings	
Built since 1946	39
Under Construction	4
Planned in next 5 years	13
Geriatric Buildings	
Built since 1946	58
Under Construction	2
Planned in next 5 years	15
Medical and Surgical Buildings	
Built since 1946	23
Under Construction	4
Planned in next 5 years	10

To date we have surveyed an excellent new receiving and intensive treatment building at Spring Grove State Hospital, Catonsville, Md.; new and functionally progressive disturbed service, medical and surgical and convalescent buildings at Springfield State Hospital, Sykesville, Md.; and an old maximum security building at St. Elizabeths Hospital, Washington, D. C., in which a modern program is being carried on.

Visits to the Virginia state hospitals were made in December 1953, and other early surveys are planned as follows: A new geriatric service at the Norristown State Hospital, Norristown, Pa.; a new children's service to open January 1st, 1954, at the Metropolitan State Hospital, Waltham, Mass.; a complete new mental hospital under construction at Northville, Mich., and a new reception center said to embody many modern principles at the Rochester State Hospital, Minn.

Information about, or invitations to visit new, functionally good mental hospital buildings throughout the country will be appreciated.

Receiving and Intensive Treatment Facility Almost a Complete Mental Hospital

By ALSTON G. GUTTERSEN

Architect to the A.P.A.-M.H.S. Architectural Study

If one could carefully examine and understand fully the purposes and programs of the Receiving and Intensive Treatment Facility in the modern mental hospital, he would have grasped the real essence of modern mental hospital treatment philosophies. For this service, more than any other one, reflects the changing attitude and treatment of nervous and mental patients. It, together with convalescing cottages which are considered as a part of it, is almost a complete mental hospital in itself.

It is to this building that all new patients come for their initial diagnosis, and, in the majority of cases, will remain for treatment until fit for discharge.

"Psychiatric hospital care and treatment begins with admission procedures," writes Dr. Riley H. Guthrie. "All the patient's experiences, which are associated with commitment, detention, transportation and admission have an effect upon him—either good or bad. Mental patients are often more sensitive to environmental influences than a healthy person. Events and persons surrounding the admission of patients are important environmental influences."

Other patient buildings are simple by comparison. Each of these—excepting those designed for the physically ill bed patients, in the medical-surgical unit, the chronically ill unit and the tuberculosis unit—are designed for small groups of individuals of a particular classification. These classifications will be determined, for design purposes, by such characteristics as behavior, age, illness, etc., each of which may require special treatment techniques. The design of units for the medical and surgical, the chronic physically ill and the tubercular patient differs widely from the design of other patient buildings, as in these buildings the bed is the place of treatment. In all other patient buildings the medical treatment program must be supported by a wide variety of occupations, recreations, exercises and other constructive activities in accordance with the requirements of the individual and the group. Buildings for these patients, will require a large percentage of their area for these activities rather than for bedroom or dormitory areas.*

The receiving and intensive treatment building has facilities for the segregate housing and treatment, in small groups, for all types of patients, for their diagnosis, for their occupation and recreation. This modern service encourages, also, a greater freedom for a greater percentage of patients. As Dr. D. Ewen Cameron has stated, the patient will not try to assume responsibility for his own life if he lives in an over-secure mental hospital.

The modern mental hospital does not reflect only secure custody, but also a simplified and controlled community in which constructive activity has been substituted for deteriorating inactivity or destructive behavior.

Even in 1869, Drs. McFarland, Patterson and Lee pointed out that the "ordinary type of lunatics—in asylums and almshouses" showed extreme depression rather than violent excitement. "What the patient needs," they continue, "is not further depression. . . . The essential elements of life, for an insane person, are the same which are essential for a man in perfect mental and bodily health . . . an increased measure of sunshine, free air, personal liberty, pleasant association and, above all, useful employment."

While today medical opinion might not agree that the majority of mental patients are depressed, the "essential elements" remain the same. As recently as 1952, we find Dr. Leslie A. Osborn writing in the *American Journal of Psychiatry:*

"Sometimes architects are unconsciously influenced by their lay ideas of mentally ill patients, and so tend to keep reintroducing maximum confinement features, which once were mistakenly thought of as 'security' measures. It takes time to have them realize that these elicit rather than control disturbed reactions."

Provision for Patient Programs

The receiving and intensive treatment service may have facilities for out-patients and day-care patients as well as for in-patients.

Out-patients may be new patients on a program of interview treatment or they may be patients on follow-up care, after having received in-patient treatment.

Day-care patients are those who require all the facilities of the psychiatric hospital except its safety and security. They may be on full-day programs of group activities in occupation, recreation, socialization, group therapy, private interviews, etc. Where the mental hospital is in or near an urban area, the receiving and intensive treatment service may develop a large out-patient and day-care program. Most mental hospitals have been too far removed from population centers to provide this service.

In-patients of the receiving and intensive treatment service may be similar to day-care patients in treatment requirements or they may need, in addition, the safety or security of the hospital. Since they are new patients, in need of very careful treatment, contact between patients of different behavior or illness should be controlled or prohibited.

Importance of Segregation

There has been, in previous building programs, a tendency to group all types of patients together regardless of behavior, age, personality, etc., so that a wide variety of illnesses had to be treated in the same situation. Under such conditions the medical staff cannot create the therapeutic environment and the organized program of activities which is required by each individual. The environment and treatment of each individual must be carefully controlled, for, in the words of Dr. D. Ewen Cameron: "We know the extent to which disturbed patients, for instance, can contaminate the rest of the ward, bringing on episodes which we have to consider as emergencies."

The importance of segregation of different types of patients into small groups cannot, therefore, be overstressed. Some patients of the receiving service will be on convalescent status and will live in nursing units that are open or unlocked. Some of these may also be in the adjacent convalescent cottages. Other patients may be quiet-cooperative, depressed or mildly over-active individuals in nursing units which may be locked only part of the time. A few will be disturbed and will be housed in nursing units which provide for the maximum security and safety of the patient. All should have

* Paul Haun, M.D., The Modern Mental Hospital, *American Journal of Psychiatry.*

access to living rooms and outdoor recreation areas immediately adjacent to their living areas, for activities of their own as well as the therapist's choice, and to central recreational and occupational therapy areas for more organized group activities.

"Fenced exercise yards, attached to ward buildings, permit a greater number of patients to be out of doors in good weather and so enjoy a freedom of movement at all hours without undue imposition on the time of nurses or attendants," wrote Dr. Sidney J. Tillim, referring to what could be done with existing facilities. "As a result, the general health of patients is conspicuously better than it is in larger institutions of this type. We believe that these exercise yards are largely responsible for an almost total absence of mechanical restraints, which had formerly been in use and for the relative lack of the so-called violent cases."

New patients, whose prognosis is unfavorable for intensive treatment, will be transferred to the continued treatment or other service after their initial work-up lasting from four to six weeks. Those new patients who fail to recover under intensive treatment in a period up to six months will also be transferred to the continued treatment or the geriatric service, whichever is indicated.

Facilities for Particular Problems

The criminally insane, alcoholics, psychopathics and other categories of court-committed patients will also be treated in separate buildings or areas specially designed for the particular problem. The effort in the receiving building is directed toward maintaining a facility for the immediate, intensive treatment of patients whose prognosis is favorable, during the early stages of their illness when treatment will do the most good.

A new pattern of facilities for nervous and mental patients may be evolving from the more recent experiences in intensive treatment programs for out-patients and in-patients. Such scientific treatments as metrazol, insulin, electric shock, group psychotherapy, group living, narcosis, etc., have only come into wide use during the last twenty years. The problem for the hospital board and the architect in programming and planning new facilities is to assist in the analysis of requirements for new treatment programs. In doing this it must be kept in mind that the architectural precedent for the most part is for custodial care only; that modern treatment techniques are extremely new and may, therefore, be exercised, if they can be used, in facilities which are inefficient, unwieldy and generally unsatisfactory for the staff and injurious to the patient; that the patient can do much for himself if given the opportunity, the proper environment and the necessary assistance. The problems in the treatment of nervous and mental patients are varied and varied resources are required to cope with them.

The modern intensive treatment facility will strive to provide a friendly, encouraging atmosphere and a program of activities, from the time of admission to discharge, for each individual patient. To accomplish this will require facilities arranged for great flexbility in the placing of patients for diagnosis and treatment, and for self-expression in work, recreation and relaxation.

Elements of the Service

The main elements of the receiving service are: administration department; out-patient department; receiving and adjunct diagnostic facilities; occupational and recreational therapy facilities, both indoor and outdoor; dietary facilities; service facilities and in-patient nursing unit facilities. In-patient nursing unit facilities include those in the adjacent convalescent cottages.

Where there is to be a large day-care program, the occupational and recreational therapy facilities, the dietary facilities and adjunct diagnostic facilities should be located between the out-patient and in-patient departments in order that cross traffic of in-patients and out-patients to these departments may be avoided as desired. Such an arrangement is illustrated in the 40- to 50-bed plans on pages 12 and 13.

Since the intensive treatment facility is the most active service of the entire mental hospital and may in fact treat more patients during the year than the other services, it is the recommendation of some hospital administrators that offices be provided in this building, rather than the main administration building, for the chief psychiatrist, chief psychologist, chief of psychiatric social service and chief of nursing services of the total hospital. The main administration building then would retain offices for the superintendent, central and inactive records, business and public contact functions.

Size Varies with Needs

The number of beds and the kind and amount of treatment facilities can only be determined by a study of requirements for the particular community. The requirements for the particular building will be affected by existing facilities, such as psychiatric services in general hospitals, special psychiatric hospitals and community health clinics in the area. They may also be affected by the presence of a recognized specialist on the staff of the proposed hospital and by the type of facility which it is proposed to construct.

An estimate of the size of this facility, size in relation to the total mental hospital, for study purposes, is approximately 6½ percent of the total mental hospital population. This is according to the late Dr. Samuel W. Hamilton and Mary Corcoran, R.N. The patients of the convalescent cottage group are then estimated to be twice that amount or approximately 13 percent of the total mental hospital population. Where additional beds are required, it is recommended that duplicate receiving and intensive treatment services be constructed.

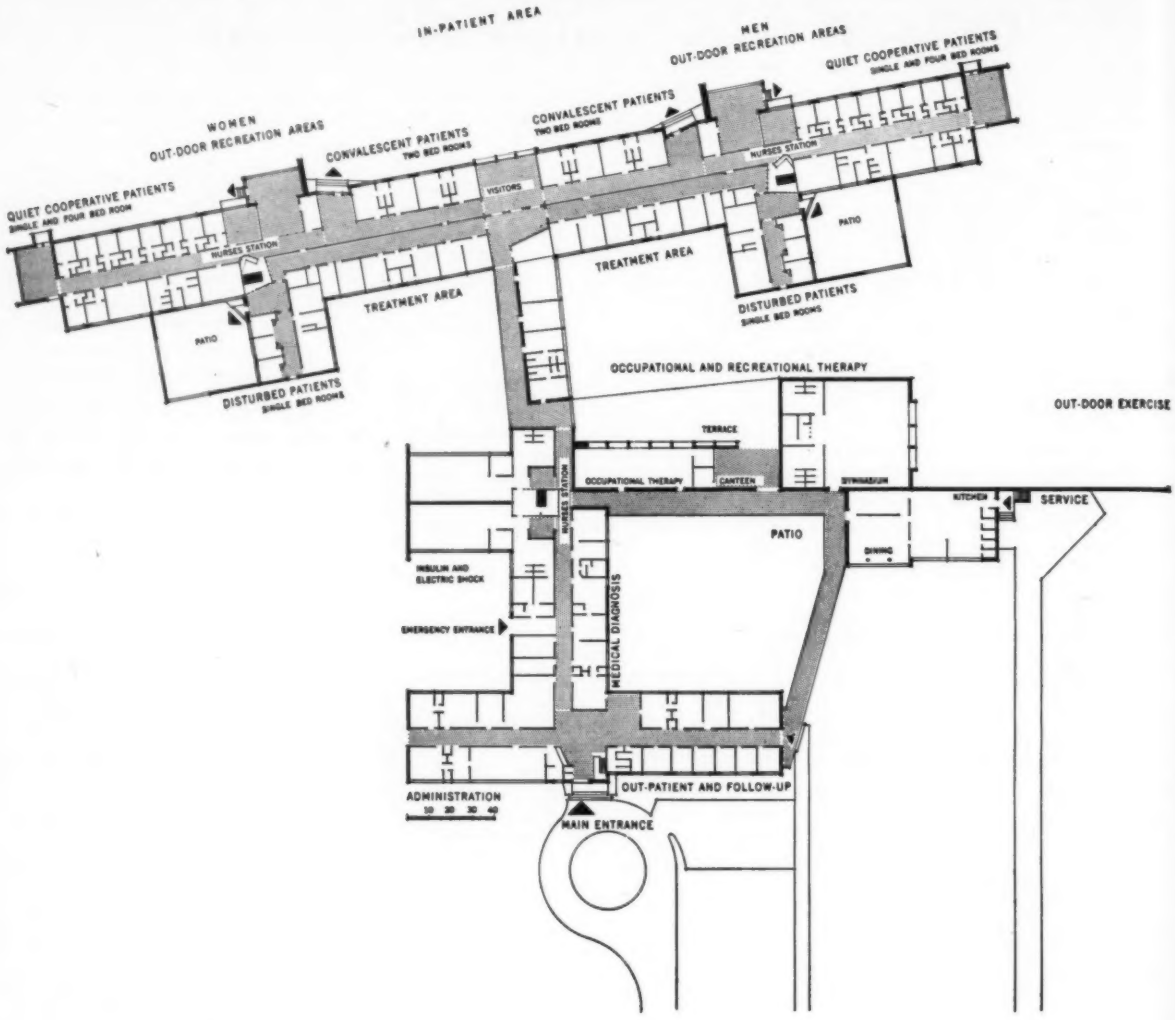
It is important to keep the receiving building small. The controlled, therapeutic environment, with opportunities to encourage the new patient in self-direction, can only be accomplished with segregated, small group conditions. Additional nursing units, again small, can be furnished in the convalescent cottages which are a part of the receiving service. These cottages may be used by all patients of the intensive treatment service excepting those requiring maximum safety and security. They offer flexibility in the placing of patients of similar behavior, age, personality, etc., who may be under similar treatment programs or who may profit by the particular group situation.

A receiving and intensive treatment service consisting of a 100-bed receiving building of four nursing units and four small convalescent cottages, together having a total of eight nursing units of 25 beds each, may be considered a maximum desirable size. Larger services tend to restrict the patient and reduce opportunities for self-expression in constructive activities.

The February issue of MENTAL HOSPITALS will carry details on location, the special facilities needed in the intensive treatment service, the requirements of the nursing units and the materials and finishes recommended.

Much of this material is reprinted by courtesy of the ARCHITECTURAL RECORD. *This and the plans on the following pages, which refer to the Intensive Treatment & Receiving Facility, were prepared under the general direction of John W. Cronin, M.D., F.A.P.A., Chief, Div. Hospital Facilities, and Marshall Shaffer, Chief, Office of Technical Services, Public Health Service, Dept. of Health, Education & Welfare.*

SUGGESTED TYPE PLAN OF 40- TO 50-BED RECEIVING & INTENSIVE TREATMENT BUILDING



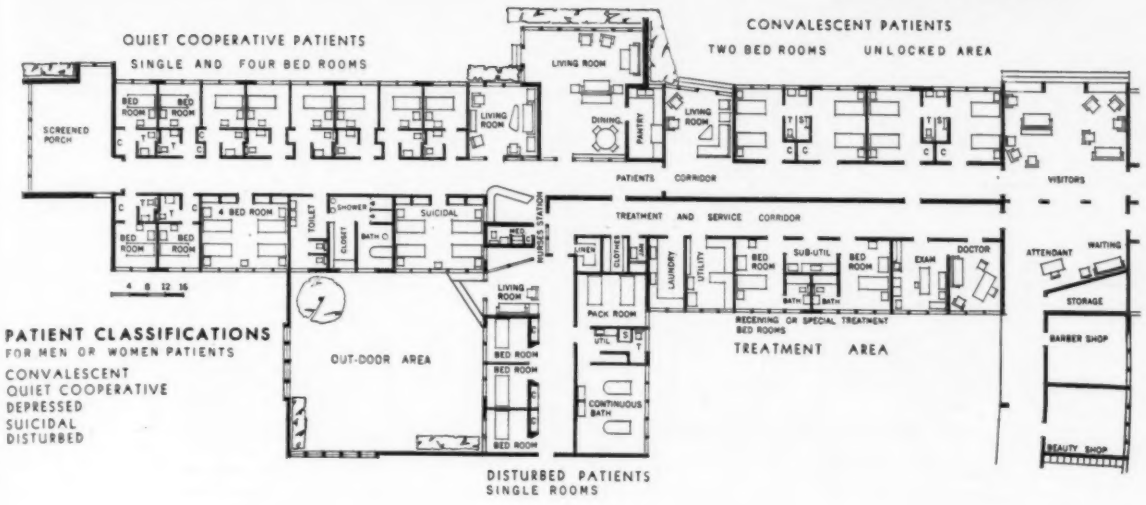
Treatment facilities in this small receiving and intensive treatment unit were expanded to provide a large out-patient service of early care, follow-up care and day care programs, and are located between out-patient & in-patient areas.

Since approximately twice as many patients under intensive treatment will be housed in adjacent "convalescent" cottages, facilities such as insulin and electric shock are larger than needed for the in-patients of this particular building.

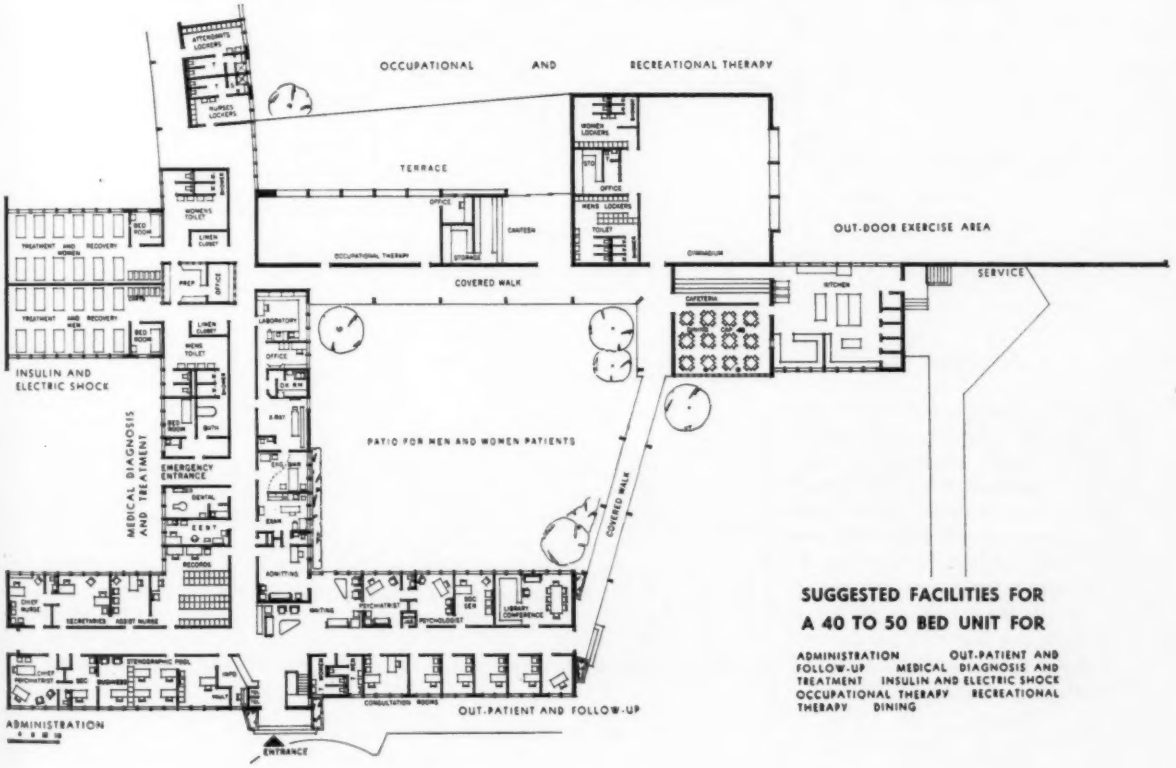
Several subdivisions of the nursing unit can be made, each having its own living room and adjacent out door areas for ward day activities. All service & medical facilities of the ward, except the pantry, are on a separate corridor of the nursing unit. The nurses' station is located near the center of the unit, near the entrance of the locked unit and has good observation of corridors and day activity areas.

"Some excellent mental hospitals have been built . . . many multi-million dollar projects are lacking in the one indispensable requirement of a mental hospital—the atmosphere of peace and comfort so important for the recovery of a mentally ill person. Why?" Daniel Blain, M.D. in "Design for Therapy."

A SUGGESTED 25 BED NURSING UNIT FOR A 40 TO 50 BED FACILITY



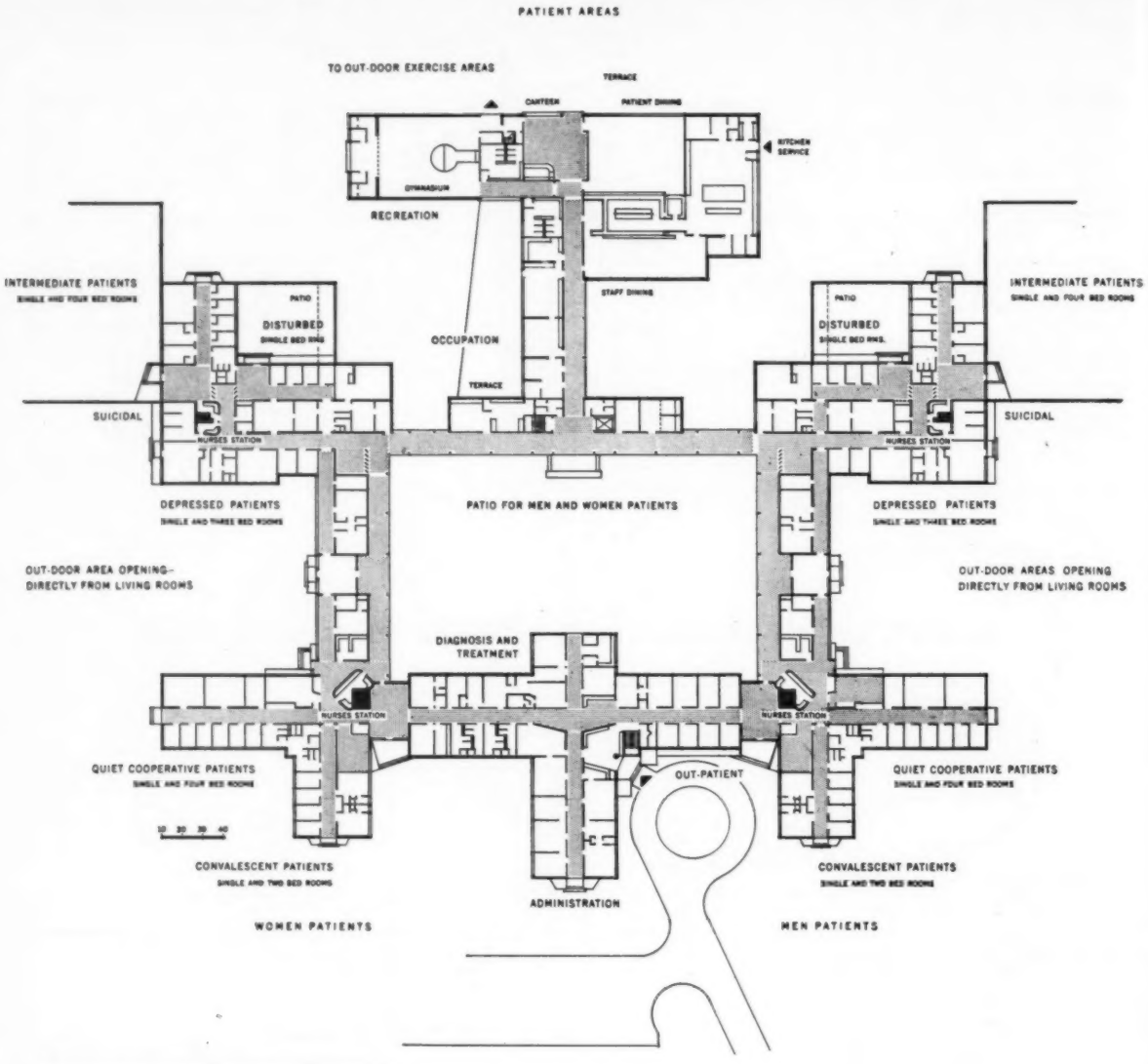
ELEMENTS OF THE RECEIVING AND INTENSIVE TREATMENT BUILDING



SUGGESTED FACILITIES FOR A 40 TO 50 BED UNIT FOR

ADMINISTRATION OUT-PATIENT AND FOLLOW-UP MEDICAL DIAGNOSIS AND TREATMENT INSULIN AND ELECTRIC SHOCK OCCUPATIONAL THERAPY RECREATIONAL THERAPY DINING

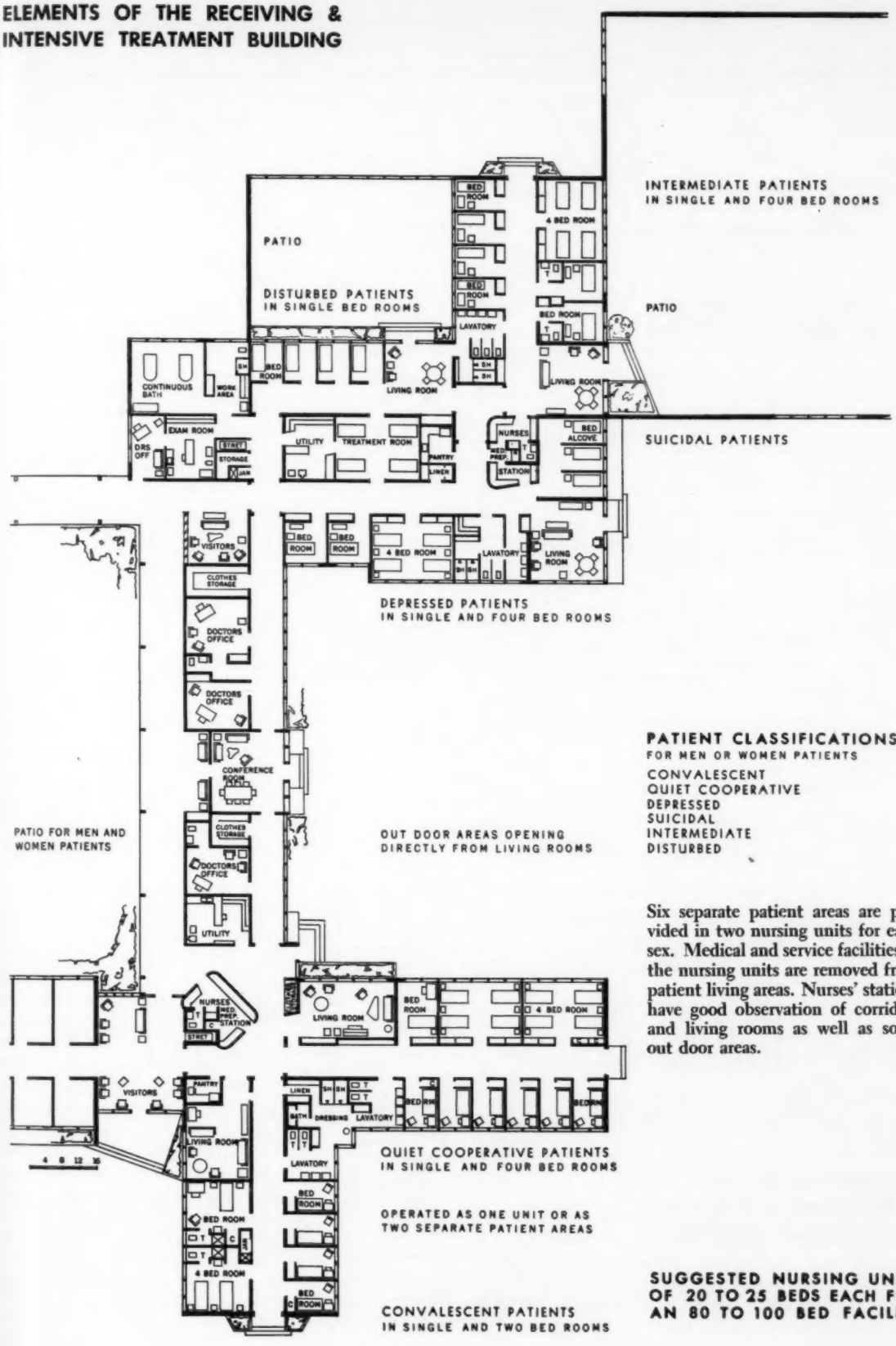
SUGGESTED TYPE PLAN OF 80- TO 100-BED RECEIVING & INTENSIVE TREATMENT BUILDING



"In our acute wards, in our reception wards, we should not just have a parlor, rooms, beds, toilets, washroom facilities. We should have facilities and space, both indoor and outdoor, for the free, uncontrolled expression of energy. Some of these people are under such tension that they need to run, to bang, to throw, to be unsocial." Kenneth E. Appel, M.D. in "Design of Therapy."

Convalescent and quiet patients are located in nursing units near the front of the building, and have access to front yard areas. Nurses' stations of the front wards have observation of front and side yards as well as the partially enclosed patio where men and women patients may be together. (Enclosed areas are detailed on succeeding pages.) Disturbed, mildly excited, depressed and suicidal patients, having separate areas, are in the nursing units to the rear of the building. All have access to out door areas from living rooms and all can be transferred easily to other areas.

ELEMENTS OF THE RECEIVING & INTENSIVE TREATMENT BUILDING

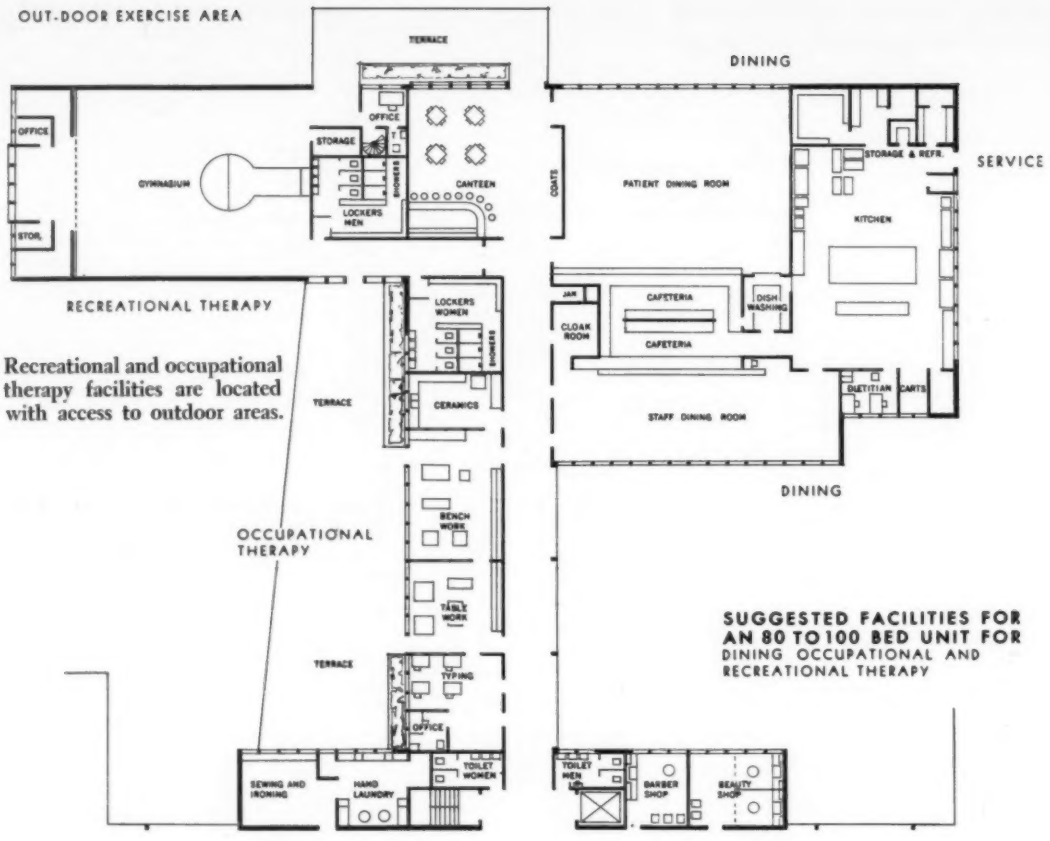


PATIENT CLASSIFICATIONS
FOR MEN OR WOMEN PATIENTS

CONVALESCENT
QUIET COOPERATIVE
DEPRESSED
SUICIDAL
INTERMEDIATE
DISTURBED

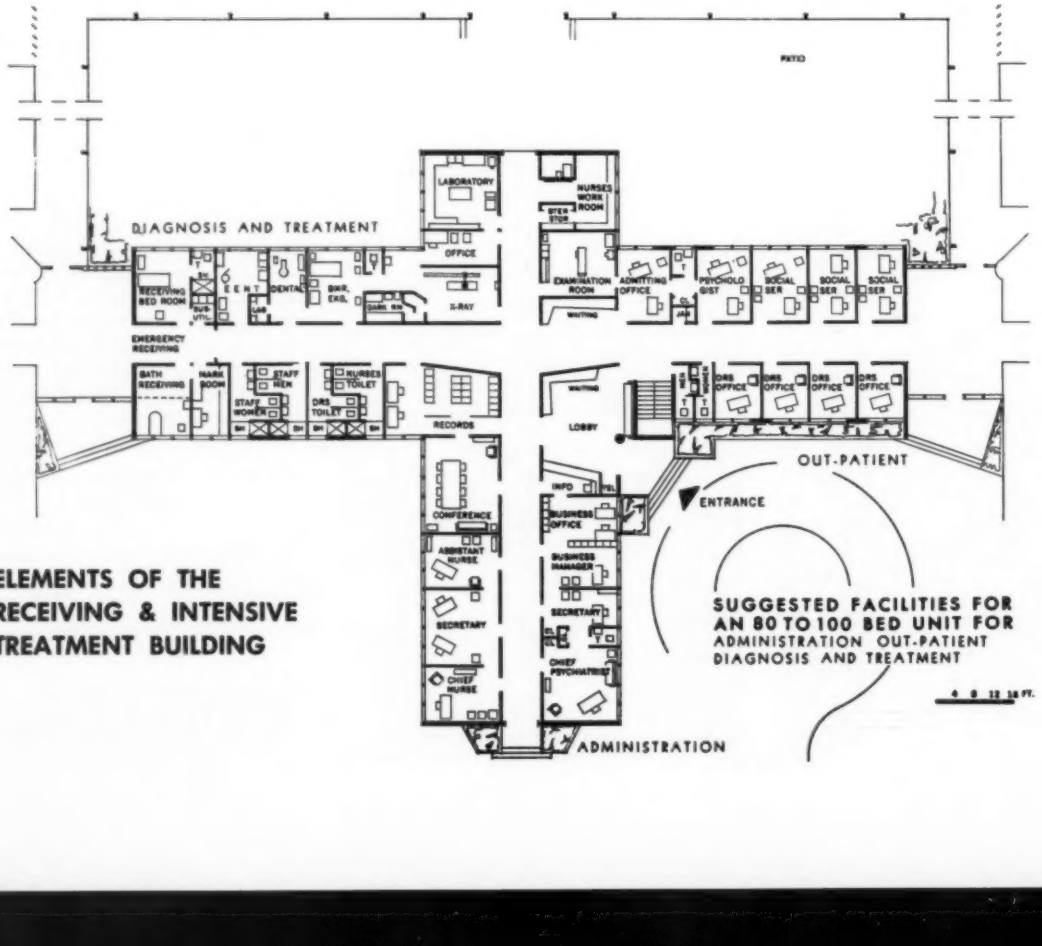
Six separate patient areas are provided in two nursing units for each sex. Medical and service facilities of the nursing units are removed from patient living areas. Nurses' stations have good observation of corridors and living rooms as well as some out door areas.

SUGGESTED NURSING UNITS OF 20 TO 25 BEDS EACH FOR AN 80 TO 100 BED FACILITY



Recreational and occupational therapy facilities are located with access to outdoor areas.

SUGGESTED FACILITIES FOR AN 80 TO 100 BED UNIT FOR
DINING OCCUPATIONAL AND RECREATIONAL THERAPY



ELEMENTS OF THE RECEIVING & INTENSIVE TREATMENT BUILDING

SUGGESTED FACILITIES FOR AN 80 TO 100 BED UNIT FOR
ADMINISTRATION OUT-PATIENT DIAGNOSIS AND TREATMENT

M. H. S. News & Notes

1954 Achievement Awards

Enclosed with this issue is the instruction sheet for submitting the applications for the 1954 Achievement Awards. Apart from the covering letter which must be sent with the description of the achievement, no application form is required.

The closing date for all applications is March 31st, 1954. Because the Chairman of the Board of Judges has to announce the results at the Annual Meeting, *no* extension can be granted to any hospital.

Every mental hospital or school for the mentally deficient in the U. S., its Territories or Canada, is eligible, whether or not it has won a previous award. Awards are made purely on merit, and no considerations of geography or previous awards are entertained.

Sixth Institute at Minneapolis

The Sixth Mental Hospital Institute will be held from October 18 through 21, 1954, at the Hotel Nicollet, Minneapolis, Minnesota. Dr. Ralph Rossen, Superintendent of the Hastings (Minn.) State Hospital is in charge of local arrangements.

New M.H.S. Consultants

Three outstanding business administrators in the mental health field have been appointed to the Mental Hospital Service Board of Consultants. The new Consultants are: Mr. Robert H. Klein, of Chicago, formerly Special Deputy to the Director of Public Welfare for Illinois; Mr. Carl E. Applegate, Deputy Director of Business Services for the California Department of Mental Hygiene; and Mr. R. Bruce Dunlap, Director of the Bureau of Institutional Management of the Pennsylvania Department of Welfare.

The new appointments were made by President Kenneth Appel after the A.P.A. Council had approved the recommendations of the M.H.S. Board of Consultants. The Board has heretofore been composed solely of psychiatrists. The appointments were made in acknowledgement of the need to bring to the Service the advice and assistance of leading lay experts in various phases of hospital adminstration.

Contributing Editors to Serve

As a means of ensuring a steady supply of information *about* mental institutions, *for* mental institutions, and *from* mental institutions, MENTAL HOSPITALS has invited some 20 persons engaged in various aspects of mental hospital work to serve as Contributing Editors.

To date, 15 of those invited have accepted the assignment of contributing five articles a year on specified topics. Eight of the new Contributing Editors are psychiatrists; the other seven represent various hospital disciplines. The psychiatrists who have accepted are Drs. E. A. Baber, Supt. of Longview State Hospital, Cincinnati, Ohio; Alfred Paul Bay, Supt. of Manteno (Ill.) State Hospital; Rupert E. Chittick, Supt. of Vermont State Hospital; James O. Cromwell, Supt. of State Hospital South, Idaho; Robert A. Kimmich, Medical Director of the Territorial Hospital, Hawaii; Lucy D. Ozarin, Chief of Hospital Psychiatry, VA Central Office, Washington, D. C.; Robert E. Wyers, Supt. of Metropolitan State Hospital, Norwalk, Calif; Randall R. MacLean, Dir. Div. Mental Health, Alberta, Canada.

Representing other disciplines are: Mr. Thomas B. Dillingham, State Vocational Rehabilitation Agency, Pueblo, Colo.; Mrs. Dorothy Hall, R.N., Director of Nursing, Oklahoma Dept. of Mental Health; Mr. F. A. Matheson, Business Manager, Provincial Mental Health Services, British Columbia; Mr. James L. O'Dell, Coordinator of Adjunctive Therapies, Parsons (Kans.) State Training School; J. Arthur Waites, Ph.D., Chief of Clinical Psychology, VA Hospital, Perry Point, Md.; Mr. E. L. Wilbur, Asst. Manager, VA Hospital, N. Little Rock, Ark.; Mr. A. C. Yopp, Asst. Director of Institutions, Topeka, Kansas.

Legislation

POLITICAL INTERFERENCE DECRIED BY A.P.A.

The American Psychiatric Association has issued a public statement urging political leaders to "take stock of the incalculable damage done when the professional staffs of our mental hospitals are sacrificed to fleeting political advantage." The Association believes that political interference with the administration of public mental hospitals in various states threatens the gains made in recent years in the care of the mentally ill.

The statement came from Dr. Kenneth E. Appel, A.P.A. President, who said that "in several states newly elected administrations have yielded to the temptation to embroil the state mental hospitals in party politics. Under one pretext or another they have removed physicians and other professional personnel hired by a previous administration. They have cut already entirely inadequate hospital budgets under the guise of 'economy.'

"The mental patients and their families are, of course, the ones who suffer most.

"Care of the mentally ill in the United States is traditionally a responsibility of the States," Dr. Appel pointed out. "The state hospitals care for about 90% of all the hospitalized mentally ill (nearly 700,000) at a cost of more than half a billion dollars annually. There is no hope for reducing this staggering burden unless the doctors, nurses, social workers, psychologists, psychiatric aides and others can work in a hospital atmosphere conducive to sound treatment, training and research.

"It is axiomatic that a good hospital abhors politics. The best public mental hospitals are in those states that have long since given professional hospital personnel status and tenure, and protected them from the ebb and flow of political change and preference."

Public Relations

HOSPITAL'S ANNUAL REPORT USED FOR PRESS RELEASE

The publication of Boston (Mass.) State Hospital's Annual Report presented Superintendent Walter E. Barton with an excellent opportunity to publicize the hospital's accomplishments and needs. A press release was issued to Boston newspapers, based on excerpts from the Annual Report with explanatory comments.

THE PATIENT DAY BY DAY

Nursing Service

AIDES' ASSOCIATION HELPS UNTIDY PATIENTS

Three years ago several of the psychiatric aides at Norwich (Conn.) State Hospital formed the Norwich Psychiatric Aide Association. Their main concern was to improve patient care, rather than to raise their own status.

The Association was endorsed by the hospital's Superintendent, Dr. Ronald H. Kettle, and he helped them draw up their charter. Today, 250 of Norwich's 350 aides are members. They adopted as their motto "More patience, less patients," and there is evidence that this philosophy has worked time and time again. The aides make their motto a working reality by taking more time, more care, in handling difficult patients.

One of the best examples was their approach to 72 untidy patients on the disturbed ward. The aides knew from their psychiatric orientation that "a human being, well or sick, will tend to take on the attitudes and behavior of his group." Accordingly they transferred six of the untidy patients to tidy wards. Gradually the six took on the clean habits of the majority. When it was felt that the improvements would stick, six other untidy patients took their place. By this means, all 72 untidy patients were rotated onto the tidy wards, and the method worked with all but six.

Many of the Association's members put in extra time working with patients. They occasionally give dances for the patients, with all expenses paid by the Association, and help support the hospital's annual Labor Day Carnival. Each Christmas they conduct a collection drive for the patients' Christmas Fund, and report very good results. At the administration's request, the Association has managed four Red Cross blood donor campaigns among hospital personnel. They were pleased when hundreds of patients volunteered to give blood also, even though they had to explain that it was not permitted.

Equipment

CIGARETTE LIGHTERS INSTALLED ON WARDS

Stationary units for lighting cigarettes have been installed on all male wards at the Fergus Falls (Minn.) State Hospital. The lighters were devised by one of the psychiatric aides, Mr. Rodger Hegman, from three manufactured parts. The lighting element, similar to an ordinary household fuse, can be easily removed if necessary, for replacement or as a fire precaution at night. The hospital reports, however, that the patients do not try to remove or abuse the element in any way.

The lighters are attached to a wall in the day room or in the area of most activity. They are operated by a contact switch which releases when pressure is removed. They also light pipes with ease, as well as cigarettes. The hospital says that the cost of the complete unit is very small, and replacement of the lighting element is seldom necessary.

"The lighter was developed primarily as a contribution to the patients' comfort and to eliminate the greater hazard of matches," the hospital notes, "but in addition we have found it to be more economical than furnishing matches."

Clinics

HOSPITAL STAFF MEMBERS AID SCHOOL CLINIC PROJECT

Because a local Kiwanis Club became interested in preventing juvenile delinquency through mental hygiene services, the public school system of Washington, D. C., has at least one psychiatric clinic. The clinic, at present the only one of its kind in the District, was set up two years ago in the high school serving the section of Washington in which the Eastern Branch Kiwanis Club operated. The Club's president at the time was Dr. Addison M. Duval, Assistant Superintendent of St. Elizabeths Hospital. The combination of positions was a fortunate one: not only did Dr. Duval "sell" the Kiwanis on the need for such a clinic, but he interested several of his hospital staff colleagues in setting it up.

With the Club's support, and the Board of Education's approval, the clinic began accepting referrals from the high school and from two nearby junior high schools, which together have a total of 3,000 students. The clinic is operated by a staff of twenty-two, most of whom volunteer their services. The seven psychiatrists are all from St. Elizabeths, as are many of the other clinic workers, which include 5 clinical psychologists, 4 psychiatric social workers, 3 registered nurses and 3 secretaries. The others were recruited from various other agencies, such as the Veterans Administration and the D. C. Health Department. In addition, there are two consultants in child psychiatry and two in neurology.

Clinic sessions are held one evening a week. When a student is first referred to the clinic, with his parents' written consent, he is given a psychiatric screening by Dr. Duval. Occasionally simple difficulties can be ironed out during the preliminary interview, or Dr. Duval recommends that the family seek private help at their own expense. The majority of cases, however, are given further treatment at the clinic. The second interview is devoted to a two-hour psychological examination of the student, while his parents are meeting with the social worker. The following week another two-hour psychological test is given. Next he is examined by a 3-member therapy team.

All these staff members then discuss their findings at a case conference. If the student is in need of psychotherapy, his case is assigned to one of the clinic's four therapy teams.

To date the clinic has processed over 50 cases. In addition, it advises teachers on what to do with "difficult" pupils.

Dr. Duval hopes that this Kiwanis-sponsored clinic will help the District of Columbia Board of Education's efforts to secure funds for similar clinics throughout the rest of Washington.

Clothing Committee Offers Statement of Basic Principles

The following are basic principles pertaining to the procurement, distribution and care of clothing for public mental hospital patients, as proposed by the A.P.A.-M.H.S. Committee on Clothing for Mental Patients with the intent of encouraging public mental institutions to achieve the highest possible standard of patient clothing:

1. Each patient needs a minimum wardrobe sufficient to ensure that he is neatly and suitably clothed for all occasions.
2. When possible, the patient should be permitted to select his own clothing.
3. The patient's clothing should be properly fitted and be designated for his personal, continuing use while hospitalized.
4. The hospital should make every effort to have the patient's family provide his clothing, and then to encourage ward personnel to see that this clothing is worn.
5. Whether patient clothing is hospital-made or whether bought on the open market or through State Use Industries, there must be sufficient variety in styles, colors and patterns to avoid uniform-like clothing.
6. Where State Use laws are mandatory, hospitals should have the prerogative of specifying their own requirements for clothing to be thus supplied, and of rejecting items which do not meet those standards.

Regarding the principles, Miss Helen Edgar, Committee Chairman, notes: "These proposals will find their major application to clothing the bulk of the hospital population—the approximately 75% who most of the time are tidy and non-destructive. All too often these patients are penalized, clothing-wise, for the small percentage of destruction which does occur. Also our hospital dress test is producing some evidence that even destructive patients will try to take better care of garments which are attractive and comfortable and which are marked with their own names."

The Clothing Committee will meet in February to work out the procedure guide concerning the procurement, distribution and care of patient clothing.

THE PSYCHIATRIST: HIS TRAINING AND DEVELOPMENT. Published by the A.P.A., Washington, D. C., November 1953. (214 pages, $2.50.)

A concise report of the 1952 Conference on Psychiatric Education, held at Cornell University, Ithaca, New York, June 1952, organized and conducted by the A.P.A. and the Association of the American Medical Colleges. Of particular interest to career psychiatrists, this volume complements the Report of the 1951 Conference which dealt with psychiatry in undergraduate medical education, published in 1952 under the title of "Psychiatry and Medical Education."

A.P.A. DESK CALENDAR AND APPOINTMENT BOOK—1954. (Price $2.00.)

A 7"x10" book with space for appointments from 7 a.m. to 9 p.m. for every day of the year. (There is even some space for Sundays.) Contains list of useful addresses of national organizations in the field, meeting dates, some "facts and figures" about psychiatry of general interest, and other helpful data. This Appointment Book will be of use to psychiatrists, psychiatric social workers and other therapists.

COMMENTARY

The second issue of *Canada's Mental Health* ("A Monthly Roundup of News Items from the Mental Health Division, Department of National Health and Welfare, Ottawa"), which made its debut in October, contains items on psychiatric nursing needs, drug addiction, child psychiatry and mental health clinics, to mention a few.

A reprint of "The Role of the Chaplain in Patient Relationships," originally published in *The Journal of Pastoral Care*, is available from the *Journal's* Editor, the Rev. Ernest E. Bruder, St. Elizabeths Hospital, Washington, D. C. The topic is in two parts, "Initial Religious Interview," by Rev. Bruder, and "Work with the Chronically Ill," by the Rev. Carl J. Schindler.

The November 15 issue of *Channels*, the bimonthly newsletter published by the National Publicity Council for Health and Welfare Services, N.Y.C., mentions the drama group organized by the Kansas City, Mo., Section of the National Council of Jewish Women. The group was organized especially to put on mental hygiene plays before civic organizations. The plays are furnished by the Kansas City Mental Hygiene Society.

"Administration is a Healing Art" is the title of an article by Dr. Richard N. Kohl, Assistant Professor of Psychiatry at the New York Hospital. The article, which appears in October's *The Modern Hospital*, applies the mental hospital precept of "therapeutic environment" to the general hospital situation.

In the same magazine is the second part of Dr. Otho F. Ball's article on Benjamin Rush, which includes some of Dr. Rush's 18th-Century observations on the treatment of mental illness. Many of them are enjoying wide use today, two centuries later: "He advocated therapeutic baths, occupational therapy, music, and a trained director over the mental department of hospitals."

The 87th annual report of St. Barnabas Hospital for Chronic Diseases, New York City, notes that its psychiatric unit, opened in 1952, is the first to be established in any hospital of its kind.

The Veterans Administration Technical Bulletin dated September 10, 1953 (TB 10-506) is concerned with "The Care and Treatment of the Psychotic Patient with Tuberculosis." Based on a survey of such patients in VA hospitals, the material was edited by Dr. Lucy D. Ozarin, Chief of Hospital Psychiatry, and covers the subject from "Case Finding" to "Morgue Technique."

Busy administrators who are called upon frequently for statistics on the various phases of their hospital's operation might be interested in the system described by Richard Gregg Jones in the November issue of *Hospitals*. Mr. Jones, who is Assistant Manager of the VA Hospital at American Lake, Wash., tells about a method used at his hospital which permits "Fingertip Availability of Statistical Data." The system is embodied in a loose-leaf record book, with a section for each of the hospital's main services.

In the December issue of *Hospitals* is an article by another VA hospital staff member. Mr. Glenn E. Morris, chief of special services at the Downey (Ill.) VA Hospital, writes general recommendations for a "Music Therapy Program for Psychiatric Patients."

A limited number of copies of "The Colorado Program of Vocational Rehabilitation for the Mentally Disabled" are available from M.H.S. at no cost. This is the paper, in mimeographed form, which Mr. Thomas B. Dillingham distributed at the Fifth Mental Hospital Institute. Mr. Dillingham is Supervisor of Special Service (Vocational Rehabilitation) for the Colorado Board for Vocational Education. The paper gives a detailed outline of Colorado's program, which began in 1947, as well as answers to such questions as "How are the ex-patients accepted by the employer and the general public?"

A.P.A. COMMITTEE TO CERTIFY ADMINISTRATORS

A new Committee to certify physicians as "qualified mental hospital administrators" has been set up by the American Psychiatric Association. The Committee, which is headed by Dr. Francis J. Braceland, Physician-in-Charge of the Institute of Living, Hartford, Conn., will conduct examinations periodically and issue qualification certificates.

In announcing the Committee's formation A.P.A. President Kenneth E. Appel said that the step was taken to help ensure that the chief executives of mental hospitals shall not only be physicians adequately trained in psychiatry, but shall also be skilled in business and personnel management, community relations, budget control and other essential administrative matters.

Dr. Appel noted that, since its founding in 1844, the American Psychiatric Association has maintained that the chief executives of mental hospitals must be physicians specialized in psychiatry. "The Association regards as unsound proposals to separate 'administrative' from 'medical' responsibility in the hospital, with corollary suggestions that doctors should confine themselves to medical matters only," he said. "It believes that all mental hospital operations bear a direct relation to the therapeutic progress of a patient, and accordingly, that only a physician may assume total responsibility for them."

Dr. Appel emphasized that this position is held without prejudice to that large body of laymen who serve as skilled and indispensable executive assistants to the chief executives of the mental hospitals.

In addition to Dr. Braceland, the new Committee is composed of Drs. Walter H. Baer, Jack R. Ewalt, Arthur M. Gee, George W. Jackson, Granville L. Jones, G. Wilse Robinson, Harold W. Sterling, Frank F. Tallman and William B. Terhune. Consultants to the Committee are: Drs. Winfred Overholser, Mesrop A. Tarumianz and Hayden H. Donahue.

Forms for applying for certification and other information may be obtained from the Secretary of the Committee, Dr. C. N. Baganz, Manager, V.A. Hospital, Lyons, New Jersey.

INDEX TO Mental Hospitals 1953

VOLUME IV